

Post-war Issues in Women's Health

We live in an increasingly globalized world that is plagued by regional, national, and international conflict, and in which migration due directly or indirectly to armed conflict is increasingly responsible for a large percentage of global migration every year.¹ Postwar migration of women presents a significant problem for health professionals and communities at large. Many women move and travel as a result of armed conflict, whether they are combatants or civilians. These women present uniquely gendered, culturally filtered physical and emotional issues that have been created by their experiences in conflict.

There are many issues faced by women in post-combat situations, from sex trafficking and domestic abuse, to drone-induced PTSD and land-mine injuries. To highlight a powerful example of how post-war experience shapes women's health, this paper will focus specifically on the ways in which post-war psychosocial trauma affects women refugees' mental health during pregnancy.

This document is intended to serve as a resource not only for community stakeholders with capacity to intervene directly in pregnant refugees' health outcomes, such as nurses and emergency health workers, but also for the general public. Most residents of communities that will increasingly host refugees in ever greater numbers have not and will not directly experience war or large-scale armed conflict. Therefore it is important that these communities understand the problems and needs that pregnant women face after being embroiled in conflict. Existing research has already demonstrated that it is critical that these health and social problems are recognized and addressed at the community

level², in a way that is comprehensive and culturally sensitive. This is an essential process to successfully and sustainably rebuild communities in the aftermath of wars and conflict, both in the native country and the destination country.

What Events Harm a Pregnant Refugee's Mental Health?

Though men certainly face intense danger of death and injury in war, women are also exposed to a host of physical and psychological injuries that can leave them with psychological trauma. This is often because of the gender specific roles that women occupy within their families and within many societies may put them at greater risk for war and post-war injury. For example, because women and girls are often responsible for going out to collect water, they are more likely to be injured by landmines³. Another example is post-war increase in domestic abuse. Priya Marwah and her colleagues observe that "where women have assumed new decision-making roles while men were off fighting, the return of men to civilian life (and often to unemployment) is sometimes associated with increased domestic violence." Other researchers agree, and note that without economic opportunities outside of urban centers, women, who in many countries are largely dependent on the family structure for social and economic support especially in conflict situations, have no means to support themselves outside of this structure and thus are less likely to disrupt the family structure by reporting

¹Deacon, Zermarie, and Cris Sullivan. "An Ecological Examination Of Rural Mozambican Women's Attainment Of Postwar Wellbeing." *Journal Of Community Psychology* 38.1 (2010): 115-130. *Academic Search Alumni Edition*. Web. 21 May 2013

² Marwah, Priya, Pamela DeLargy, and Lara Tabac. "Disarmament, Demobilisation And Reintegration: Opportunities In Post-Conflict Settings." *Forced Migration Review* (2010): 12-13. *Academic Search Alumni Edition*. Web. 7 June 2013.

domestic abuse.⁴ The most common risk, to health and well-being that women in war zones face, however, is unwanted sexual encounter and sexual trauma. In conflict situations, women are vulnerable to forced prostitution, rape, and/or being used as sexual collateral for bartering by their families⁵.

These are only a few examples of the traumas that women can face during conflict. In these violent and socially fragile situations, both before and after the conflict, the effects of these traumas may be compounded by economic, social, and physical threat against reporting and seeking counseling. These stresses and traumas in the wake of war produce a great risk of poor birth outcomes in pregnant refugees, and though there is an increasing number initiatives to address the negative influence that these psychological stressors have on pregnant women, psychosocial programs for pregnant women are severely lacking.⁶

Since our focus is on pregnant *refugees*, there is of course the added consideration of postwar *migration*, which further complicates the needs and problems faced by pregnant women after armed conflicts, whether they are returning veterans or asylum seekers and refugees. A cross-sectional study performed in Sweden assessed the difference in mental health problems between male and female refugee and non-refugee immigrants from six low-income

countries in Sweden⁷. This study confirmed that being a refugee in a high-income country, especially a female refugee, puts one at increased risk of severely poor mental health. In fact, even compared to other female immigrants, the study found that female refugees were at a greater risk for poor mental health. This phenomenon is not isolated to Sweden or countries like it. A survey study performed in Afghanistan found that in the wake of war, women moving within the country had significantly lower mental health status and poorer social functioning than did men, exhibiting higher prevalence of depression and PTSD⁸.

How Can We Improve Pregnant Refugees' Mental Health?

It is important that healthcare professionals accurately understand and treat the mental health needs of women immigrating or returning to a country after war, and it is important for communities to be built in which the adjustment or readjustment process to the new civilian, peacetime setting can be stable and supported rather than compounding the stresses that women have experienced in the conflict setting. For refugees and asylum seekers who likely have little to no experience in the new country, it is critical that healthcare professionals and community institutions communicate with these women in a way that is sensitive to their native cultures and to their often traumatic wartime experiences. Resources must be devoted to creating health care services

³ Desai, Sapna, and Melissa J. Perry. "Tracking Gender-Based Human Rights Violations In Postwar Kosovo." *American Journal Of Public Health* 94.8 (2004): 1304-1307. *Academic Search Alumni Edition*. Web. 22 May 2013.

⁴ McCormack, Lynne. "Civilian Women At War: Psychological Impact Decades After The Vietnam War." *Journal Of Loss & Trauma* 14.6 (2009): 447-458. *Academic Search Alumni Edition*. Web. 22 May 2013.

⁵ Akesson, Bree. "Addressing The Psychosocial Needs Of Pregnant Women Affected By War: Program Approaches And Program Gaps." *Refuge* 25.1 (2008): 55-59. *Academic Search Alumni Edition*. Web. 30 May 2013.

⁶ Solvig Ekblad, et al. "Gender-Related Mental Health Differences Between Refugees And Non-Refugee Immigrants- A Cross-Sectional Register-Based Study." *BMC Public Health* 11.1 (2011): 180-187. *Academic Search Alumni Edition*. Web. 7 June 2013.

⁷ Trani, Jean-François, and Parul Bakhshi. "Vulnerability And Mental Health In Afghanistan: Looking Beyond War Exposure." *Transcultural Psychiatry* 50.1 (2013): 108-139. *Academic Search Alumni Edition*. Web. 7 June 2013.

and education in the language(s) of the community in question that work cooperatively within the framework of the cultural roles and assumptions of the societies that these women come from rather than attempting to force them to rapidly adopt entirely new ideologies and health beliefs irrespective of their cultural context.

Previously cited research suggests that stable family structure and support is critical for helping women deal with post-conflict trauma and social readjustment, whether in the home country or in a new one. Therefore it is worthwhile for researchers and policy makers to explore ways in which strong family support for women refugees and veterans can be fostered by investing in family stability with either economic assistance and counseling and/or social programs and counseling.

Another commonly proposed solution is the establishment of psychosocial groups that provide supportive, safe spaces for women to convene and address their psychosocial problems or receive education and referral to resources regarding their psychosocial needs. A major advantage of these forums may be that women are particularly receptive to mental health education during pregnancy, when they concerned with protecting all possible aspects of their and their baby's health.⁹ Another advantage is the opportunity to have women gathered with other women from their home country or ethnic group so that the space is culturally comfortable and familiar to them. This sense of comfort and support from women in situations similar to theirs presents the chance to allow these women to see themselves as strong and in control of their life situation and pregnancy outcomes. With proper guidance from a healthcare counseling professional, this could present an

exciting opportunity for women to identify their own mental and physical health needs, as well as ways that are within their power to address them. This "strengths-based vernacular," in which refugee women can see themselves as self-confident, self-empowered agents, is often lacking in many health and counseling programs for pregnant refugees, where they tend to be characterized and addressed as victims. Promoting the principle of dignity in pregnancy may be an invaluable way to improve pregnant refugees' health by helping women see that with the support, their mental and physical health is in their hands, and within a supportive social and institutional framework, they and their unborn children can thrive.

Links to other resources:

1. "Critical Issues-- Women and War", womenforwomen.org:

<http://www.womenforwomen.org/news-women-for-women/women-and-war.php>

2. "Global Reproductive Health," cdc.gov:

<http://www.cdc.gov/reproductivehealth/Global/>

⁸ Akesson, Bree. "Addressing The Psychosocial Needs Of Pregnant Women Affected By War: Program Approaches And Program Gaps." *Refuge* 25.1 (2008): 55-59. *Academic Search Alumni Edition*. Web. 2 June 2013.